

# **EXHIBIT 1**

O L S H A N

O L S H A N G R U N D M A N F R O M E R O S E N Z W E I G & W O L O S K Y L L P

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July 26, 2006

By Federal Express

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Fox Rothschild LLP  
2000 Market Street, Tenth Floor  
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1201 North Market Street, Suite 1400  
Wilmington, DE 19801

Re: Koken, etc. v. GPC International, Inc. (United States District Court,  
District of Delaware, Civil Action, No. 05-223)

Dear Jerry and Sean:

Enclosed for each of you is a copy of the amended petition (including the exhibits thereto) which we understand was filed on July 21, 2006 in proceedings in California in connection with the worker's compensation claims of Frank Jamaica.

Sincerely yours,



Herbert C. Ross, Jr.

cc: John Seaman, Esq. (with enclosure by Federal Express)  
Cheryl Garber, Esq. (with enclosure by Federal Express)

508894-1

NEW JERSEY OFFICE  
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**TROVILLION, INVEISS, PONTICELLO & DEMAKIS**

WCAB CODE: B8499

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1906 Commercenter East, Suite 200  
San Bernardino, California 92408-3424  
(909) 890-2441

Attorneys for Defendant

**WORKERS' COMPENSATION APPEALS BOARD**

**STATE OF CALIFORNIA**

FRANK JAMAICA,

Applicant,

v.

GPC INTERNATIONAL, dba PLANHOLD;  
CIGA administered by its servicing facility)  
CAMBRIDGE INTEGRATED SERVICES  
GROUP, INC.; ZURICH-AMERICAN  
INSURANCE GROUP;

Defendants.

CASE NOS: ANA 0311896;  
ANA 0311897

**AMENDED PETITION FOR  
CONTRIBUTION/REIMBURSEMENT**

COMES NOW DEFENDANT, CALIFORNIA INSURANCE GUARANTEE ASSOCIATION,  
(hereinafter CIGA), administered by its servicing facility, CAMBRIDGE INTEGRATED SERVICES  
GROUP, INC., on behalf of RELIANCE INSURANCE COMPANY (in Liquidation), by and through  
its attorneys of record, TROVILLION, INVEISS, PONTICELLO & DEMAKIS, and hereby amends its  
Petition for Contribution and petitions for contribution/reimbursement of benefits paid to date.

**FACTUAL HISTORY**

Applicant, Frank Jamaica, born April 8, 1960, while employed as an assembler for GPC  
INTERNATIONAL, dba PLAN HOLD CORP., (hereinafter "GPC"), allegedly sustained injury to  
his groin, right leg, and left shoulder arising out of two specific injuries (January 10, 1995, and April

1 19, 1996), and an alleged cumulative trauma for the period of April 19, 1995, through April 19,  
2 1996.

3 GPC was insured for workers' compensation by RELIANCE INSURANCE COMPANY for  
4 the period including January 10, 1995, through June 30, 1995. GPC was insured by ZURICH-  
5 AMERICAN INSURANCE GROUP (hereinafter "ZURICH") for the period of July 1, 1995, through  
6 April 19, 1996.<sup>1</sup> Based on these coverage dates, Reliance had coverage for 73 days out of the year  
7 preceding the April 19, 1996 injury. This amounts to 20% of the last year of industrial exposure.  
8 ZURICH had coverage for 293 days, or 80% of the last year of industrial exposure.

9 Although the applicant submitted DWC 1 claim forms for three industrial injuries, he has  
10 only filed Applications for Adjudication of Claim for two of the injuries:

11  
12 1. Case Number ANA 0311896 is a specific injury which occurred on January 10, 1995  
13 (Reliance Coverage). The original DWC-1, written by the employer's representative and signed by  
14 the employee, describes the injury location as "the right leg". ( The claimant waited 21 days to report  
15 this alleged injury.) This claim for benefits was filled out February 1, 1995. (EXHIBIT A)

16 A second DWC 1 Claim for benefits for the same injury date (January 10, 1995) was  
17 typed and reported on March 17, 1997. It states that his groin, right leg and shoulder were injured  
18 (this is the first mention of a shoulder injury) "while holding cabinet, standing on conveyor, I stepped  
19 on the tape table. It moved, I fell into split position and fell off table onto floor." (EXHIBIT B) On  
20 the same date, an Application for Adjudication of Claim was completed by applicant's attorney,  
21 Brent M. Thompson. (EXHIBIT C)

22 2. On April 25, 1996, (Zurich coverage) an Employee's Claim for Workers  
23 Compensation Benefits was filled out and signed by the applicant. It claimed a date of injury of  
24 April 19, 1996 (Zurich coverage) with the injury being "epididymitis" (EXHIBIT D). No  
25 Application for Adjudication of Claim was filed for that specific date of injury.

26  
27  
28 <sup>1</sup> Zurich's actual policy period extended to June 30, 1996. On January 4, 1996, Zurich changed  
its policy period from a mid-year policy period to a calendar year policy December 31, 1995 to  
December 31, 1996.

1           3.       A date of injury of April 19, 1995, through April 19, 1996, CT (cumulative trauma)  
2 was typed on a Claim for Benefits dated March 17, 1997. This claim form described the injury and  
3 body part affected as "groin, right leg, shoulder, stress and strain of regular job duties." (EXHIBIT  
4 E) (It should be noted that this was the first mention of a shoulder injury.) An Application for  
5 Adjudication of Claim was filed on the same date for this injury, resulting in a Case Number of ANA  
6 0311897. (EXHIBIT F)

7           The first medical report describing the applicant's January 10, 1995 injury is dated February  
8 2, 1995. Mr. Jamaica went to Pacific Walk-In Medical Center in Fountain Valley. He saw Dr.  
9 Jeffrey Sudeith. He stated that "while working, packing cabinets, I felt a pull in my right leg." He  
10 was diagnosed with a groin strain with epididymitis. (EXHIBIT G) He was returned to work with  
11 limitations of no lifting over thirty pounds. He also had limitation of avoiding repetitive bending,  
12 stooping or squatting through February 6, 1995. (EXHIBIT H) These work restrictions remained in  
13 effect until March 1, 1995, at which time a work status form from Pacific Walk-In Medical Center  
14 stated Mr. Jamaica was discharged to return to work unrestricted. (EXHIBIT I) (This January 10,  
15 1995 claim was closed by Reliance in April of 1995 with total expenditures of \$247.00. Mr.  
16 Jamaica worked with minimum sick time for the remainder of 1995).

17           A February 6, 1995, Supervisor's Report of Injury states that Mr. Jamaica was packing  
18 cabinets and using a lift table which moved. He had a right groin strain. (EXHIBIT J)

19           For the April 19, 1996, injury (Zurich coverage) for which Mr. Jamaica filed an April 25,  
20 1996, DWC-1 for epididymitis, a contemporaneous Supervisor's Report of Injury was signed by Jim  
21 H., and states that the employee was "working on a master file." The accident occurred "when he  
22 was moving the master file." He suffered "muscle strain." A note at the bottom of this report states  
23 that "employee opted to wait until Monday the 22nd to go to the doctor." (EXHIBIT K)

24           On a Work Status Form of April 25, 1996, (Zurich coverage) he was given a return to work  
25 with limitations of "no lifting more than five pounds, sedentary bench or desk work preferred, avoid  
26 repetitive bending, stooping or squatting, should avoid prolonged walking or standing. Not  
27 permitted to work on ladder, scaffolding, poles or above ground level." (EXHIBIT L) A Doctor's  
28 First Report of Occupational Injury or Illness, dated April 25, 1996, by David Dunckel, M.D. stated

1 that "the April 19, 1996 accident happened when he was working in the line at work. He works on a  
2 table, the table started to roll, he fell into the split. Groin injury." It also states that the patient's  
3 handwritten signed description is on the file. This report also described a similar accident by  
4 Applicant of "one year ago".(EXHIBIT M)

5 In his deposition, taken March 3, 1999, Mr. Jamaica testified that his shoulder had  
6 hurt him right away, but his testicular pain was worse. (However, the first mention of a shoulder  
7 injury was in the history of injury by Dr. Martin Klein (April 23, 1997) in an Internal Medicine  
8 AME.) Mr. Jamaica also testified that the left shoulder pain increased with the April, 1996, injury  
9 (even though the first medical report of the April 19, 1996, injury did not contain any mention of a  
10 shoulder injury). He also testified that the testicular pain was worse after the April, 1996, injury.  
11 (EXHIBIT N: pages 27-31, Deposition).

12 Over the next two years, Mr. Jamaica saw several doctors regarding his testicular pain  
13 and shoulder pain. He saw Dr. Scott Lee regarding his testicular pain. In October, 1996, the report  
14 was that his constant pain was worse with movement. Dr. Lee's chart notes also state that Mr.  
15 Jamaica had testicular pain for eight months previously. He opined several causes including mumps.  
16 (EXHIBIT T) In November, 1996, he stated he had thigh and back pain that radiated. He stated it  
17 was sharp pain. In February, 1997, he saw Dr. D. House and told him his injury in April, 1996, was  
18 due to a moving belt.

19 Dr. Clifford Marshall, an Agreed Medical Examiner Urologist, on June 3, 1997,  
20 stated that over 1½-2 years he aggravated his injury several times while performing his usual and  
21 customary job functions. He further opined that the applicant was permanent and stationary.  
22 (EXHIBIT O: AME Report 6/3/97,p.7)

23 Also, in June, 1997, Dr. Stephen M. Ma wrote in a report to Zurich that in reviewing  
24 the medical records the one thing that was consistent was that the patient's history concerning his  
25 injuries was inconsistent. He pointed out that not only did different medical reports state different  
26 methods of injury, but that in some reports he claimed no other injuries, and in other reports he  
27 mentions the original (January, 1995) injury, and in some reports he includes the shoulder injury.  
28 However, Dr. Ma felt that there was no cumulative trauma, but two separate injuries. (EXHIBIT P:

1 6/2/97 Report, p.11) Dr. Ma also opined that the January 10, 1995, injury was diagnosed as a leg  
2 strain with epididymitis, generally not an industrial injury. He also comments that medical records  
3 before 1997 do not support the current work injury claim of an injury to his left shoulder.

4 Mr. Jamaica was sent to Dr. H. Rahman for an Orthopedic Consultation (1-27-98),  
5 after which he became the primary treating physician. Dr. Rahman declared Mr. Jamaica permanent  
6 and stationary orthopedically on September 2, 1999.

7 Finally, on April 5, 2004, WCALJ Nancy Gordon approved the Compromise and  
8 Release settlement agreement on both case numbers ANA 0311896 (January 10, 1995) and ANA  
9 0311897 (04/19/95 -04/19/96 CT). A true and correct copy of the Order Approving and the  
10 Compromise and Release agreement is attached hereto and incorporated herein by reference as  
11 EXHIBIT Q.

### 12 13 DISCUSSION

14 Importantly, Mr. Jamaica was never declared temporarily totally disabled after the  
15 January 10, 1995, injury. He was returned to full duty on March 1, 1995, and the claim was  
16 subsequently closed by Reliance in April, 1995, after paying the nominal medical expenses.

17 However, after Mr. Jamaica saw the doctor on April 23, 1996, (now under Zurich's  
18 coverage) he was declared to be temporarily totally disabled for four days. Further, it is obvious that the  
19 modified work duties were much greater after this April 19, 1996 injury (i.e., no lifting over 30 pounds  
20 for the first injury and no lifting over 5 pounds for this second injury, etcetera). (EXHIBIT H&L)

21 Clearly, the medical reporting also shows that Dr. Rahman was confused between the  
22 two specific injuries. His November 24, 2003, letter states that the second injury (April, 1996, Zurich  
23 coverage) caused his increased level of pain and discomfort, especially to the shoulder  
24 region."(EXHIBIT R)

25 Dr. Rahman also refers to Mr. Jamaica's deposition testimony recalling pages 27-29 in  
26 which the applicant states that his testicular pain increased after the April 19, 1996, injury to the point  
27 of vomiting. Inexplicably, Dr. Rahman then confirms two separate injuries and charges a greater  
28 percent of disability to the first injury.

1 Mr. Jamaica was returned to full duty March 3, 1995. He did not seek industrial medical  
2 treatment again until April 23, 1996, over one year later and AFTER the April 19, 1996 injury. As  
3 mentioned previously, after his April 25, 1996, visit to Pacific Walk-In Medical Center, his work  
4 restrictions are much more severe (EXHIBIT L).

5 Although the disability is (erroneously) apportioned by Dr. Rahman (11-23-04 letter) (EXHIBIT  
6 R), the expenses should not be because Mr. Jamaica's medical expenses greatly increased AFTER the  
7 second injury (under Zurich coverage), due to the second injury.

8 Also, the medical reports are inconsistent in the reporting of the history of this claim. (See Dr.  
9 Ma (June 2, 1997 report) page 11).

10 Further, the many physicians who evaluated Mr. Jamaica cannot decide as to whether or not there  
11 was a cumulative trauma. Dr. Jack Piasecki stated that there are two separate injuries. However, Dr.  
12 Piasecki noticed an increase in pain after the April, 1996, injury. Dr. Rahman adopts Dr. Piasecki's  
13 reasoning (11/23/04) although he admits that "the April 19, 1996 injury (Zurich coverage) caused his  
14 increased level of pain and discomfort, especially to the shoulder region." (November, 2003, letter)  
15 Once again, there is no mention of a shoulder injury until 1997.

16 Dr. Marshall's report dated June 3, 1997, opines that the applicant's pain and injury were  
17 aggravated over 1½-2 years. (EXHIBIT O) If the pain and injury occurred over a period of 1 ½ years,  
18 the whole injury claim would be under the Zurich coverage. If the injury occurred over a 2 years period  
19 (in actuality a cumulative trauma), the claim's expenses would either be subject to apportionment  
20 between CIGA (Reliance) and Zurich or totally the responsibility of ZURICH under Labor Code §  
21 1063.1.

### 22 23 REIMBURSEMENT CONTRIBUTION REQUESTED

24 In this case, all benefits, as well as the proceeds from the Compromise and Release, were paid  
25 by defendant California Insurance Guarantee Association (CIGA). Based on the foregoing facts and  
26 discussion, CIGA requests the issuance of an Order Compelling Defendant Zurich to Reimburse CIGA  
27 under the following theories:

28 I. If it is determined that a cumulative trauma can be gleaned from Dr. Marshall's report

(June 3, 1997), Zurich would have to reimburse CIGA all of the expenses of this case due to Labor Code § 1063.1. CIGA is not liable for any part of any injury if a solvent insurer is liable for any part of the injury. (*CIGA v. WCAB*) (Weitzman) 128 Cal. App. 4<sup>th</sup> 307 (2005); *CIGA v. WCAB* (Hooten) 128 Cal.App. 4<sup>th</sup> 569.

Further, case number ANA 03118967 was filed as a cumulative trauma, and the Compromise and Release approved on April 5, 2004, settled this case. Therefore, a cumulative trauma was settled and the aforementioned Labor Code § 1063.1 applies.

Finally, the applicant's own testimony in his March 10, 1990 deposition lends credence to this result as does the aforementioned report of Dr. Marshall.

**Defendant CIGA's total claim for reimbursement, therefore, equals \$331, 579.64.**

**II.** In the alternative, if it is determined that there are two separate and distinct injuries, it is obvious that Mr. Jamaica returned to full duty after his treatment for his original injury. On March 1, 1995, he returned to work and performed his full duties for over 1¼ years until his April 19, 1996, injury under Zurich's coverage period. With a specific injury, Zurich should owe all of the medical, temporary disability, permanent disability, and rehabilitation expenses as the carrier in the last year of industrial exposure (Labor Code §5500.5).

**Defendant CIGA's total claim for reimbursement, therefore, equals \$331,579.64.**

**III.** In another alternative, Zurich owes at least 80% (293 days of 365 days) of the expense of this claim to CIGA.

1. By virtue of their coverage period during the last year prior to the injury (July 1, 1995-April 19, 1996).

2. By virtue of the testimony by the applicant that his pain was worse following the second injury.

3. After the first injury, he returned to work and full duty. After the Zurich injury (April 19, 1996), the applicant had to have multiple surgeries and be vocationally retrained.

The expenditures were:

**Medical Expenditures:** **\$131,036.63 x 80% = \$104,829.30**

**Temporary Disability:** **\$ 87,853.25 x 80% = \$ 70,282.60**

**Rehabilitation Expenditures:** **\$ 15,189.76 x 80% = \$ 12,151.81**

**Permanent Disability Settlement Proceeds:      \$ 97,500.00 x 80% = \$ 78,000.00**

**Defendant CIGA's total claim for reimbursement, therefore, equals \$265,263.71.**

Attached hereto as Petitioner's EXHIBIT S is a true and correct copy of a printout of all benefits paid prior to the issuance of the Compromise and Release agreement, as well as benefits paid pursuant to the Order Approving Compromise and Release.

Defendant CIGA respectfully requests that an Order issue compelling co-defendant ZURICH to reimburse CIGA for the amount of \$331,579.64 in total. In the alternative, Defendant CIGA respectfully, requests that an Order issue compelling co-defendant ZURICH to reimburse CIGA for the amount of \$265,263.71.

By copy of this Petition and Exhibits, and based upon all pleadings and medical evidence, the Petitioner, California Insurance Guarantee Association (CIGA) requests contribution and reimbursement from Zurich-American Insurance Group as the Court so orders.

Dated: 7/21/06

Respectfully submitted,

TROVILLION, INVEISS, PONTICELLO &amp; DEMAKIS

BY

Cary Brown Hewitt

CARYN BROWN MERIWETHER  
Attorney for Defendant

**PROOF OF SERVICE BY MAIL**

STATE OF CALIFORNIA, COUNTY OF SAN BERNARDINO

COURT: Workers' Compensation Appeals Board  
CASE TITLE: Frank Jamaica v. GPC International  
CASE NUMBER: ANA 0311896; ANA 0311897

I, Julie Juarez, declare as follows:

I am employed with the law firm of Trovillion, Inveiss, Ponticello & Demakis, 1906 Commercenter East, Suite 200, San Bernardino, CA 92408. I am readily familiar with the business practices of this office for collection and processing of correspondence for mailing with the United States Postal Service; I am over the age of eighteen and I am not a party to this action.

On July 21, 2006, I served the following:

**AMENDED PETITION FOR CONTRIBUTION/REIMBURSEMENT**

on the below parties in this action by placing a true copy (copies) thereof in a separate envelope(s), addressed as shown, for collection and mailing on the below indicated day pursuant to the ordinary business practice of this office which is that correspondence for mailing is collected and deposited with the U.S. Postal Service on the same day in the ordinary course of business:

WORKERS COMPENSATION APPEALS BOARD  
28 CIVIC CENTER PLAZA, ROOM 451  
SANTA ANA, CA 92701

FRANK JAMAICA  
2115 PARK DRIVE  
SANTA ANA CA 92702;

CAMBRIDGE INTEGRATED SERVICES GROUP, INC.  
P O BOX 15901  
SACRAMENTO, CA 95822  
Claim No(s): 0027405665; 0027416593  
Attention Roberta Williams

ZURICH-AMERICAN INS. GROUP, REP. BY TOBIN-LUCKS  
18201 VON KARMAN AVENUE, STE 440, IRVINE CA 92612  
Attention Mia Evans

CRAIG S. WASSERMAN  
12362 BEACH BLVD. STE 15  
SEASIDE CA 90680

(Enclosed Copy)  
WORKERS' COMPENSATION JUDGE,  
Retired  
Arbitration and Mediation Services  
P.O. Box 662  
Newport Beach, CA 92661  
Attention Phillip A. Mark

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on July 21, 2006, at San Bernardino, California.

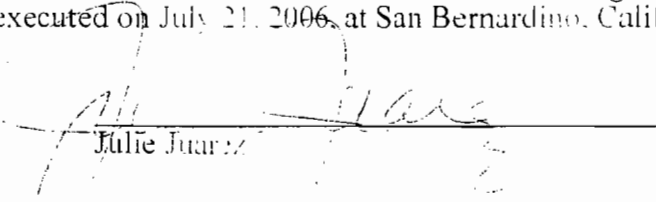
  
Julie Juarez

EXHIBIT A

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State of California  
Department of Industrial Relations  
DIVISION OF WORKERS' COMPENSATION



Departamento de Relaciones Industriales  
DIVISION DE COMPENSACIÓN DEL TRABAJADOR

### EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

### RECLAMO DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si usted se ha lesionado o se ha enfermado en o a causa de su trabajo, Ud. tiene derecho de recibir beneficios de compensación del trabajador.

Complete la sección "Empleado" y entregue el reclamo a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar este reclamo o para obtener sus beneficios, póngase en contacto con la Oficina Estatal de Asistencia para Beneficios y Ejecución de la ley (Aplicación) llamando al 1-800-736-7401. Al dorso de esta forma se encuentra una explicación de los beneficios de compensación del trabajador.

Ud. también debería de haber recibido de parte de su empleador un folleto describiendo los beneficios de compensación del trabajador lesionado y el procedimiento para obtenerlos.

#### Employee Empleado:

1. Name Nombre Jose Tamarica Today's Date Fecha de hoy 2-1-95
2. Home address Dirección 600 W 35th St #B118
3. City Ciudad Santa Ana State Estado CA Zip Código Postal 92701
4. Date of injury. Fecha de la lesión (accidente). 1-10-95 Time of injury Hora en que ocurrió 9:30 a.m. p.m.
5. Address/place where injury happened. Dirección/lugar dónde ocurrió el accidente Plan Hotel working
6. Describe injury and part of body affected. Describa la lesión y la parte del cuerpo afectada. the right leg

#### 7. Signature of employee. Firma del empleado.

Jose Tamarica

#### Employer (complete this section and give the employee a copy immediately as a receipt):

#### Empleador: (complete esta sección y dele inmediatamente una copia al empleado como recibo):

8. Name of employer. Nombre del empleador Plan Hotel Int'l.
- Address Dirección 17421 von Karman - Irvine 92714
9. Date employer first knew of injury. Fecha en que el empleador supo por primera vez de la lesión o accidente. 1-31-95
10. Date claim form was provided to employee. Fecha en que se le entregó al empleado el reclamo. 2-1-95
11. Date employer received claim form. Fecha en la que el empleado devolvió el reclamo completado al empleador.
12. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. Reliance Insurance 3355 Michelson Rd Irvine 92714
13. Signature of employer representative. Firma del Representante del Empleador. Kathleen Beach
14. Title Título mfg. assist. 15. Telephone Teléfono 661-4411

**Employer:** You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within one working day of receipt of completed form from employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

**Empleador:** Es requerido que Ud. feche este documento y que provea copias del mismo a su compañía de seguros y al empleado, representante o persona que dependa de él, que haya completado el reclamo, dentro de un día hábil después de haber recibido la solicitud completada de parte del empleado.

EL FIRMAR ESTE DOCUMENTO NO SIGNIFICA ADMISION DE RESPONSABILIDAD

**EXHIBIT B**

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State of California  
Department of Industrial Relations  
DIVISION OF WORKERS COMPENSATION



Estado de California  
Departamento de Relaciones Industriales  
DIVISION DE COMPENSACIÓN AL TRABAJADOR

### EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the Division of Workers' Compensation at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

**Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.**

### RECLAMO DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado en/o a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

Complete la sección "Empleado" y entregue la forma a su empleador. Quedese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, póngase en contacto con la División de Compensación al Trabajador al 1-800-736-7401. Al dorso de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

**Toda aquella persona que con conocimiento haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".**

Employee: Empleado:

1. Name. Nombre. Frank Jamaica Today's Date. Fecha de Hoy. 3/17/97
2. Home Address. Dirección Residencial. 2115 Park Drive
3. City. Ciudad. Santa Ana State. Estado. CA Zip. Código Postal. 92707
4. Date of Injury. Fecha de la lesión (accidente). 1/10/95 Time of Injury. Hora en que ocurrió. \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.
5. Address and description of where injury happened. Dirección y descripción del lugar dónde ocurrió el accidente.  
Irvine, CA
6. Describe injury and part of body affected. Describa la lesión y parte del cuerpo afectada. While holding cabinet, standing on conveyer, I stepped on the tape table it moved, I fell into split position, then fell off table onto floor injuring my groin, right leg and shoulder
7. Social Security Number. Número de Seguro Social del Empleado. 561 99 1776
8. Signature of employee. Firma del empleado. [Signature]

Employer—complete this section and give the employee a copy immediately as a receipt.

Empleador—complete esta sección y déle inmediatamente una copia al empleado como recibo.

9. Name of employer. Nombre del empleador. \_\_\_\_\_
10. Address. Dirección. \_\_\_\_\_
11. Date employer first knew of injury. Fecha en que el empleador supo por primera vez de la lesión o accidente. \_\_\_\_\_
12. Date claim form was provided to employee. Fecha en que se le entregó al empleado la forma del reclamo. \_\_\_\_\_
13. Date employer received completed claim form. Fecha en que el empleador recibió la forma del reclamo completado. \_\_\_\_\_
14. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. \_\_\_\_\_
15. Insurance Policy Number. El número de la póliza del Seguro. \_\_\_\_\_
16. Signature of employer representative. Firma del representante del empleador. \_\_\_\_\_
17. Title. Título. \_\_\_\_\_
18. Telephone. Teléfono. \_\_\_\_\_

**Employer:** You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within one working day of receipt of completed form from employee.

**Empleador:** Se requiere que Ud. feche esta forma y que propée copias a su compañía de seguros y empleado, dependiente o representante que haya presentado este reclamo dentro del plazo de un día hábil desde el momento de haber sido recibida la forma

EXHIBIT C

---

STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
**WORKERS' COMPENSATION APPEALS BOARD**

SEE REVERSE SIDE  
FOR INSTRUCTIONS

**APPLICATION FOR ADJUDICATION OF CLAIM**  
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. \_\_\_\_\_

Mr. Frank Jamaica \_\_\_\_\_

2115 Park Drive \_\_\_\_\_

(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No.: 561 99 1776 \_\_\_\_\_

Santa Ana, CA 92707 \_\_\_\_\_

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)

VS.

Plan Hold \_\_\_\_\_

(EMPLOYER--STATE IF SELF-INSURED)

(APPLICANT'S ADDRESS AND ZIP CODE)

17421 Von Karman \_\_\_\_\_

Irvine, CA 92714 \_\_\_\_\_

(EMPLOYER'S ADDRESS AND ZIP CODE)

P.O. Box 25099 \_\_\_\_\_

Santa Ana, CA 92799 \_\_\_\_\_

(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

Reliance Insurance \_\_\_\_\_

(EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

**IT IS CLAIMED THAT:**

1. The injured employee, born 4/8/60, while employed as a Assembler  
(DATE OF BIRTH) (OCCUPATION AT TIME OF INJURY)  
on 1/10/95 at Irvine, CA  
(DATE OF INJURY) (ADDRESS) (CITY) (STATE) (ZIP CODE)

By the employer sustained injury arising out of and in the course of employment to

Groin, right leg & shoulder

(STATE WHAT PARTS OF THE BODY WERE INJURED)

2. The injury occurred as follows: Fell off conveyor while pulling cabinet.  
(EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at the time of injury were: Appr \$9.30 per hour 40 hours per week per O.T.  
(GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)

(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows: Various dates  
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)
5. Compensation was paid X \$ Subject to Proof  
(YES) (NO) (TOTAL PAID) (WEEKLY RATE) (DATE OF LAST PAYMENT)
6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury  
XX  
(YES) (NO)

7. Medical treatment was received XX All treatment was furnished by  
(YES) (NO) (DATE OF LAST TREATMENT)  
the Employer or Insurance Company XX Other treatment was provided or paid by \_\_\_\_\_  
(YES) (NO)

Did Medi-Cal pay for any health care related to this claim XX doctors not provided or paid for by employer or insurance company who treated or examined  
(YES) (NO)  
for this injury are Bristol Park Medical, 2720 S. Bristol #224, Santa Ana, CA 92707  
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

8. Other cases have been filed for industrial injuries by this employee as follows: \_\_\_\_\_  
Companion Filing 4/19/95-4/19/96 C.T.  
(SPECIFY CASE NUMBER AND CITY WHERE FILED)

9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity XX  
Permanent disability indemnity XX Reimbursement for medical expense XX Medical treatment XX  
Compensation at proper rate XX Rehabilitation XX other (Specify) All benefits  
available pursuant to Labor Code AND APPLICANT REQUESTS A HEARING AND

AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at Santa Ana, California 3/17/97  
(CITY) (DATE)

Brent M. Thompson \_\_\_\_\_

540 N. Golden Circle #109  
Santa Ana, CA 92705 714/973-8321

(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

(APPLICANT'S SIGNATURE)

EXHIBIT D

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State of California  
Department of Industrial Relation  
DIVISION OF WORKERS' COMPENSATION



Estado de California  
Departamento de Relaciones Industriales  
DIVISION DE COMPENSACIÓN DEL TRABAJADOR

### EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you are entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the State's Office of Benefit Assistance and Enforcement at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

### RECLAMO DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si usted se ha lesionado o se ha enfermado en o a causa de su trabajo, Ud. tiene derecho de recibir beneficios de compensación del trabajador.

Complete la sección "Empleado" y entregue el reclamo a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar este reclamo o para obtener sus beneficios, póngase en contacto con la Oficina Estatal de Asistencia para Beneficios y Ejecución de la ley (Aplicación) llamando al 1-800-736-7401. Al dorso de esta forma se encuentra una explicación de los beneficios de compensación del trabajador.

Ud. también debería de haber recibido de parte de su empleador un folleto describiendo los beneficios de compensación del trabajador lesionado y el procedimiento para obtenerlos.

**Employee Empleado:** Frank Jamaica

1. Name Nombre Frank Jamaica Today's Date Fecha de hoy 4-25-96

2. Home address Dirección 2115 S PARK

3. City Ciudad S ANA CA State Estado CA Zip Código Postal 92707

4. Date of injury. Fecha de la lesión (accidente). 4-19-96 Time of injury Hora en que ocurrió 9:30 a.m. \_\_\_\_\_ p.m.

5. Address/place where injury happened. Dirección/lugar dónde ocurrió el accidente PLAN HOLD CORP

6. Describe injury and part of body affected. Describa la lesión y la parte del cuerpo afectada. epididymitis

7. Signature of employee. Firma del empleado. [Signature]

**Employer** (complete this section and give the employee a copy immediately as a receipt):  
**Employador:** (complete esta sección y dele inmediatamente una copia al empleado como recibo)

8. Name of employer. Nombre del empleador Plan Hold Corp

Address Dirección 17421 Von Karman Ave - Irvine 92714

9. Date employer first knew of injury. Fecha en que el empleador supo por primera vez de la lesión o accidente. 4-19-96

10. Date claim form was provided to employee. Fecha en que se le entregó al empleado el reclamo. 4-24-96

11. Date employer received claim form. Fecha en la que el empleado devolvió el reclamo completado al empleador. \_\_\_\_\_

12. Name and address of insurance carrier or adjusting agency. Nombre y dirección de la compañía de seguros o agencia administradora de seguros. Zurich American Ins. PO Box 2400 Woodland Hills CA.

13. Signature of employer representative. Firma del Representante del Empleador. Kathleen Beach

14. Title Título Mfg. Assistant 15. Telephone Teléfono 714 660-8400

**Employer:** You are required to date this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within **one working day** of receipt of completed form from employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

**Empleador:** Es requerido que Ud. feche este documento y que provea copias del mismo a su compañía de seguros y al empleado, representante o persona que dependa de él, que haya completado el reclamo, dentro de un día hábil después de haber recibido la solicitud completada de parte del empleado.

EL FIRMAR ESTE DOCUMENTO NO SIGNIFICA ADMISION DE RESPONSABILIDAD

EXHIBIT E

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State of California  
Department of Industrial Relations  
DIVISION OF WORKERS COMPENSATION



Estado de California  
Departamento de Relaciones Industriales  
DIVISION DE COMPENSACIÓN AL TRABAJADOR

### EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

If you are injured or become ill because of your job, you may be entitled to workers' compensation benefits.

Complete the "Employee" section and give the form to your employer. Keep the copy marked "Employee's Temporary Receipt" until you receive the dated copy from your employer. You may contact the Division of Workers' Compensation at 1-800-736-7401 if you need help in filling out this form or in obtaining your benefits. An explanation of workers' compensation benefits is included on the reverse of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

**Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.**

### RECLAMO DEL EMPLEADO PARA BENEFICIOS DE COMPENSACIÓN DEL TRABAJADOR

Si Ud. se ha lesionado o se ha enfermado en o a causa de su trabajo, Ud. tiene derecho a recibir beneficios de compensación al trabajador.

Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia fechada de su empleador. Si Ud. necesita ayuda para completar esta forma o para obtener sus beneficios, póngase en contacto con la División de Compensación al Trabajador al 1-800-736-7401. Al dorso de esta forma se encuentra una explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

**Toda aquella persona que con conocimiento haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".**

Employee: *Empleado:*

1. Name. *Nombre.* Frank Jamaica Today's Date. *Fecha de Hoy.* 3/17/97
2. Home Address. *Dirección Residencial.* 2115 Park Drive
3. City. *Ciudad.* Santa Ana State. *Estado.* CA Zip. *Código Postal.* 92707
4. Date of Injury. *Fecha de la lesión (accidente).* 4/19/95 Time of Injury. *Hora en que ocurrió.* \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.
5. Address and description of where injury happened. *Dirección y descripción del lugar dónde ocurrió el accidente.*  
Irvine, CA
6. Describe injury and part of body affected. *Describe la lesión y parte del cuerpo afectada.* Groin, Right Leg, Shoulder Stress & Strain of Regular Job Duties
7. Social Security Number. *Numero de Seguro Social del Empleado.* 561 99 1776
8. Signature of employee. *Firma del empleado.* \_\_\_\_\_

Employer—complete this section and give the employee a copy immediately as a receipt.

*Empleador—complete esta sección y dele inmediatamente una copia al empleado como recibo.*

9. Name of employer. *Nombre del empleador.* [Signature]
10. Address. *Dirección.* \_\_\_\_\_
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* \_\_\_\_\_
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la forma del reclamo.* \_\_\_\_\_
13. Date employer received completed claim form. *Fecha en que el empleador recibió la forma del reclamo completado.* \_\_\_\_\_
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* \_\_\_\_\_
15. Insurance Policy Number. *El numero de la póliza del Seguro.* \_\_\_\_\_
16. Signature of employer representative. *Firma del representante del empleador.* \_\_\_\_\_
17. Title. *Título.* \_\_\_\_\_
18. Telephone. *Teléfono.* \_\_\_\_\_

Employer: You are required to file this form and provide copies to your insurer and to the employee, dependent or representative who filed the claim within one working day of receipt of completed form from employee.

*Empleador: Se requiere que Ud. feche esta forma y que provea copias a su compañía de seguros y empleado, dependiente o representante que haya presentado este reclamo dentro del plazo de un día hábil desde el momento de haber sido recibida la forma completa del empleado.*

SIGNING THIS FORM IS AN ADMISSION OF LIABILITY

EXHIBIT F

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112

STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS

## WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE  
FOR INSTRUCTIONSAPPLICATION FOR ADJUDICATION OF CLAIM  
(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. \_\_\_\_\_

Mr. Frank Jamaica

2115 Park Drive

(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No.: 561 99 1776

Santa Ana, CA 92707

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)

vs.

Plan Hold

(EMPLOYER--STATE IF SELF-INSURED)

(APPLICANT'S ADDRESS AND ZIP CODE)

17421 Von Karman  
Irvine, CA 92714

(EMPLOYER'S ADDRESS AND ZIP CODE)

P.O. Box 2400  
Woodland Hills, CA 91365

(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

Zurich-American

(EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

## IT IS CLAIMED THAT:

1. The injured employee, born 4/8/6p, while employed as a Assembler  
(DATE OF BIRTH) (OCCUPATION AT TIME OF INJURY)  
on 4/19/95-4/19/96 at Irvine, CA  
(DATE OF INJURY) (ADDRESS) (CITY) (STATE) (ZIP CODE)

By the employer sustained injury arising out of and in the course of employment to  
Groin, Right Leg, Shoulder

(STATE WHAT PARTS OF THE BODY WERE INJURED)

2. The injury occurred as follows: Stress & Strain of Regular Job Services  
(EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at the time of injury were: \$9.50 per hour/40 hours per week & O.T.  
(GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)

(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows: Various Dates  
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)
5. Compensation was paid XX \$ Subject to Proof  
(YES) (NO) (TOTAL PAID) (WEEKLY RATE) (DATE OF LAST PAYMENT)
6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury  
XX  
(YES) (NO)

7. Medical treatment was received XX 2/28/97 All treatment was furnished by  
(YES) (NO) (DATE OF LAST TREATMENT)  
the Employer or Insurance Company XX Other treatment was provided or paid by  
(YES) (NO)

Did Medi-Cal pay for any health care

(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)  
related to this claim XX doctors not provided or paid for by employer or insurance company who treated or examined  
(YES) (NO)  
for this injury are Bristol Park Medical, 2720 S. Bristol Street #224, Santa Ana, C  
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

8. Other cases have been filed for Industrial Injuries by this employee as follows:  
Companion Filing 1/11/95

(SPECIFY CASE NUMBER AND CITY WHERE FILED)

9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity XX  
Permanent disability indemnity XX Reimbursement for medical expense XX Medical treatment XX  
Compensation at proper rate XX Rehabilitation XX Other (Specify) all available  
benefits pursuant to Labor code. AND APPLICANT REQUESTS A HEARING AND

AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at Santa Ana, California 3/17/97  
(CITY) (DATE)

Brent M. Thompson

540 N. Golden Circle #109  
Santa Ana, CA 92705 714/973-8321

(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

(APPLICANT'S SIGNATURE)

EXHIBIT G

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PACIFIC WALK-IN MEDICAL

P.O. BOX 9208

MOUNTAIN VALLEY, CA 92708

Clinic: 714/863-9103 Office: 714/966-6624

Number: 33-0591684

DOCTOR'S FIRST REPORT OF  
OCCUPATIONAL INJURY OR ILLNESS  
State of California

7178

Failure to file in 5 days may result in civil penalty.

1. Insurer: RELIANCE INSURANCE  
SANTA ANA CA 92709

P.O. BOX 25099

2. Employer: PLAN HOLD CORP.  
IRVINE CA 927143. Address: 17421 VON KARMAN AVENUE  
ATTN: RENATA KOPPER

4. Business: MFG.OFFICE FURNITURE

5. Patient: JAMAICA, JOSE NMI

6. Sex: MALE 7. B/D: 04/08/60

8. Address: 600 W. 3rd STREET  
APT. #B-118

SANTA ANA CA 92701

9. Phone: 714-836-8065

10. Occupation: ASSEMBLER

11. SSN: 561-99-1776

12. Injured at: EMPLOYER'S ADDRESS(ABOVE)

County: ORANGE

13. Injured: 01/10/95 10:00 AM 14. Last worked: 02/01/95

15. First exam: 02/01/95 04:15 PM 16. Previously treated here: NO

17. History:

PATIENT STATES "WHILE WORKING PACKING CABINETS I FELT A PULL IN  
MY RIGHT LEG" DENIES OTHER INJURIES.

18. Subjective Complaints:

AS ABOVE

19. Objective Findings:

TENDER RIGHT CORD. NO HERNIA PALPABLE. NO DISCHARGE.

X-ray and Laboratory Findings:

NONE

20. Diagnosis:

1. GROIN STRAIN WITH EPIDIDYMITIS.

Previous Injuries: NONE STATED

Allergies: NKA

Tetanus Toxoid: LESS THAN FIVE YEARS

Major Hand: RIGHT

1. Are findings consistent with history? YES

2. Is there any condition that will delay recovery? NO

3. TREATMENT

EXAM, VIBRATABS #20 DISP., MOTRIN 600mg #40 DISP., RETURN TO WORK  
WITH LIMITATIONS 02/01/95, RETURN TO CLINIC 02/06/95.

First aid? NO Further treatment: RETURN TO CLINIC 02/06/95 Duration:

4. Work Status: Able to return to usual work: / / ; Modified work: 02/01/95

Work restrictions: NO LIFTING &gt; 30 lbs

Doctor's signature:

Report date: 02/02/95

Doctor(s): JEFFREY SUBERITA, MD License: G50344

I, the undersigned, being a duly licensed physician, do hereby certify that the  
person who makes or causes to be made any knowingly false fraudulent statement or material representation for the  
purpose of obtaining or denying Worker's Comp. Benefits is guilty of a felony.

3

EXHIBIT H

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2362 Morse Avenue  
Irvine, CA 92714  
(714) 863-9103

3100 W. Warner Ave.  
Santa Ana, CA 92704  
(714) 546-4233

22741 La Brea Street  
Lake Forest, CA 92630  
(714) 581-3011

Date/Time

In

Dr.

Physical Therapy

Out

71785

Employee: Jamaica Jose

Employer: Plan Held D.O.I. 7/10/95

## WORK STATUS FORM

RIGHT OR LEFT		DIAGNOSIS				
Abdomen	Ear	Heel	Shoulder	Abrasion	Dislocation	Overuse
Ankle	Elbow	Hip	Skin	Abscess	Epicondylitis	Syndrom
Back	Eye	Index Finger	Skull	Allergy	Foreign Body	Paronychia
Big Toe	Eyebrow	Jaw	Teeth	Amputation	Fracture	Puncture
Calf	Face	Knee	Tendon	Avulsion	Ganglion Cyst	Rust Ring
Cervical	Finger(s)	Lip	Thigh	Burn - Thermal	Hematoma	Sprain
Spine	Digits: 1 2 3 4 5	Lower Leg	Thumb	Burn - Chemical	Hernia	Strain
Chest	Foot	Lumbar	Toe(s)	Bursitis	Infection	Subungual
Chin	Forearm	Spine	Tongue	Carpal Tunnel	Inflammation	Hematoma
Coccyx	Forehead	Nail	Upper Arm	Cellulitis	Inhalation	Tendinitis
Conjunctiva	Grown	Neck	Wrist	Chemical	Irritation	Tenosynovitis
Cornea	Hand: <input type="checkbox"/> R <input type="checkbox"/> L	Nose		Conjunctivitis	Laceration	Trauma
Dorsal	Dominant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Rib		Contusion	Myositis	<input type="checkbox"/> Non-Occupational
Spine	Head	Scalp		Dermatitis	Neuritis	

Other/Comments: Epididymitis

WORK STATUS		PHYSICAL THERAPY	
<input type="checkbox"/> Off Work	thru	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Frequency: <input type="checkbox"/> Daily
<input checked="" type="checkbox"/> Return to Work with Limitations (see below)	2-1 thru 2-6		<input type="checkbox"/> 3 Treatments
<input type="checkbox"/> Return to Full Duty Unrestricted	3 thru	<input type="checkbox"/> Evaluate and Treat (First P.T. Visit)	<input type="checkbox"/> 2 Treatments
<input type="checkbox"/> Discharged to Return to Work Unrestricted	DATE	<input type="checkbox"/> Protocol	Precautions/Special Instructions:
		Scheduled with Another Facility <input type="checkbox"/>	

NOTICE OF LIMITATIONS ☐ FIRST NOTICE ☐ REVISED NOTICE ☐ NO CHANGE FROM PREVIOUS VISIT

- ☒ Lifting or carrying: Not permitted to lift, carry, push or pull more than 30 pounds.
- ☐ Sedentary bench or desk work preferred.
- ☐ Repetitive, awkward positions: Must avoid repeated bending or motions of the
- ☒ Bending and stooping: Must avoid repetitive bending, stooping or squatting.
- ☐ Walking or standing: Should avoid prolonged or sustained walking or standing.
- ☐ Work at ground level: Not permitted to work on ladders, scaffoldings, poles, roof or above ground level.
- ☐ Hazardous machinery: Not permitted to operate hazardous machinery or tools.
- ☐ Motor vehicles: Should not operate personal or company vehicle.
- ☐ Ventilated area: Work area must be adequately ventilated.
- ☐ Solvents and other chemicals: Must avoid contact with solvents, oils, acids, detergents or other chemicals.
- ☐ Keep clean and dry: Wound site and all dressings, bandages, etc., must avoid exposure to liquids, dirt, grease, oils or other contaminating agents.
- ☐ Overhead lifting: Must avoid overhead work.
- ☐ Eye patch: Must wear eye patch as directed and avoid hazardous machinery and driving.
- ☐ Splint/Brace: Must wear as directed.
- ☐ Special and Miscellaneous:

Medical Provider

#

EXHIBIT I

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Medical Center  
2362 Morse Avenue  
Irvine, CA 92714  
(714) 863-9103

Medical Center  
3100 W. Warner Ave.  
Santa Ana, CA 92704  
(714) 546-4233

Medical Center  
22741 Lar Street  
Lake Forest, CA 92630  
(714) 581-3011

Date/Time

Employee: Jamaica Jose  
Employer: PLAN Hold D.O.I. \_\_\_\_\_

Physical Therapy  
In \_\_\_\_\_  
Dr \_\_\_\_\_  
Out \_\_\_\_\_

## WORK STATUS FORM

RIGHT OR LEFT		DIAGNOSIS				
Abdomen	Ear	Heel	Shoulder	Abrasion	Dislocation	Overuse Syndrome
Ankle	Elbow	Hip	Skin	Abscess	Epicondylitis	Paronychia
Back	Eye	Index Finger	Skull	Allergy	Foreign Body	Puncture
Big Toe	Eyebrow	Jaw	Teeth	Amputation	Fracture	Rust Ring
Calf	Face	Knee	Tendon	Avulsion	Ganglion Cyst	Sprain
Cervical Spine	Finger(s)	Lip	Thigh	Burn - Thermal	Hematoma	Strain
	Digits: 1 2 3 4 5	Lower Leg	Thumb	Burn - Chemical	Hernia	Subungual Hematoma
Chest	Foot	Lumbar Spine	Toe(s)	Bursitis	Infection	Tendinitis
Chin	Forearm	Nail	Tongue	Carpal Tunnel	Inflammation	Tenosynovitis
Coccyx	Forehead	Neck	Upper Arm	Cellulitis	Inhalation	Trauma
Conjunctiva	Groin	Nose	Wrist	Chemical	Irritation	
Cornea	Hand: <input type="checkbox"/> R <input type="checkbox"/> L	Rib		Conjunctivitis	Laceration	<input type="checkbox"/> Non-Occupational
Dorsal Spine	Dominant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Scalp		Contusion	Myositis	
	Head			Dermatitis	Neuritis	

Other/Comments: \_\_\_\_\_

WORK STATUS		PHYSICAL THERAPY	
<input type="checkbox"/> On Work	thru _____ NEXT APPT. _____	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	<input type="checkbox"/> Daily
<input type="checkbox"/> Return to Work with Limitations (see below)	3/1 thru 2/3 NEXT APPT. _____	<input type="checkbox"/> Frequency: _____	<input type="checkbox"/> 3 Treatments
<input checked="" type="checkbox"/> Return to Full Duty Unrestricted	3/1 thru 3/1 NEXT APPT. _____	<input type="checkbox"/> Evaluate and Treat (First P.T. Visit)	<input type="checkbox"/> 2 Treatments
<input checked="" type="checkbox"/> Discharged to Return to Work Unrestricted	DATE 3/1	<input type="checkbox"/> Protocol	Precautions/Special Instructions: _____
		Scheduled with Another Facility <input type="checkbox"/>	

### NOTICE OF LIMITATIONS ☐ FIRST NOTICE ☐ REVISED NOTICE ☐ NO CHANGE FROM PREVIOUS VISIT

- ☐ Lifting or carrying: Not permitted to lift, carry, push or pull more than \_\_\_\_\_ pounds.
- ☐ Sedentary bench or desk work preferred.
- ☐ Repetitive, awkward positions: Must avoid repeated bending or motions of the \_\_\_\_\_
- ☐ Bending and stooping: Must avoid repetitive bending, stooping or squatting.
- ☐ Walking or standing: Should avoid prolonged or sustained walking or standing.
- ☐ Work at ground level: Not permitted to work on ladders, scaffoldings, poles, roof or above ground level.
- ☐ Hazardous machinery: Not permitted to operate hazardous machinery or tools.
- ☐ Motor vehicles: Should not operate personal or company vehicle.
- ☐ Ventilated area: Work area must be adequately ventilated.
- ☐ Solvents and other chemicals: Must avoid contact with solvents, oils, acids, detergents or other chemicals.
- ☐ Keep clean and dry: Wound site and all dressings, bandages, etc., must avoid exposure to liquids, dirt, grease, oils or other contaminating agents.
- ☐ Overhead lifting: Must avoid overhead work.
- ☐ Eye patch: Must wear eye patch as directed and avoid hazardous machinery and driving.
- ☐ Splint/Brace: Must wear as directed.
- ☐ Special and Miscellaneous: \_\_\_\_\_

Medical Provider \_\_\_\_\_

# 30

1/10/95

# PLAN HOLD

## SUPERVISOR'S REPORT OF INJURY

1. EMPLOYER <b>PLAN HOLD CORPORATION</b>		3. NATURE OF BUSINESS <b>SHEET METAL FABRICATION</b>	
2. LOCATION <b>17421 Van Kaman Drive (60714)</b>			
4. NAME OF INJURED EMPLOYEE <b>JOSE Jaramila</b>		5. SEX: <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
6. OCCUPATION		8. SUPERVISOR <b>Jim Humphries</b>	
7. DEPARTMENT IN WHICH REGULARLY EMPLOYED <b>Assembly</b>		9. WHERE DID ACCIDENT OR EXPOSURE OCCUR? <b>at work</b>	
10. ON EMPLOYER'S PREMISES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		11. WHAT WAS EMPLOYEE DOING WHEN INJURED? <b>He was packing the new cabinets on the new line (Post 2000) cabinet</b>	
12. HOW DID ACCIDENT OR EXPOSURE OCCUR? <b>When he was packing the cabinet (Pos 2000) and the lift table moved and he strain a muscle on his right leg</b>			
13. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE <b>Lift table</b>			
14. NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED <b>Right leg</b>			
15. DATE OF INJURY OR ILLNESS MO. <b>1</b> DAY <b>10</b> YEAR <b>95</b>		16. TIME OF DAY <b>9:30</b> <input checked="" type="radio"/> A.M. <input type="radio"/> P.M.	
17. HAS EMPLOYEE RETURNED TO WORK? <input checked="" type="checkbox"/> YES, DATE RETURNED <input type="checkbox"/> NO, STILL OFF WORK			
18. WAS FIRST AID ADEQUATE TREATMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		19. DID EMPLOYEE GO TO THE DOCTOR? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20. IF YES, NAME OF DOCTOR OR CLINIC <b>Pacific Walk-in</b>		21. DID AN UNSAFE CONDITION CONTRIBUTE TO THE ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
22. EXPLAIN  			
23. DID THE EMPLOYEE COMMIT AN UNSAFE ACT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24. EXPLAIN  			
25. PERSONAL FACTORS THAT COULD HAVE CONTRIBUTED TO THE ACCIDENT <input type="checkbox"/> IMPROPER ATTITUDE <input type="checkbox"/> BODILY DEFECTS (EYESIGHT, HEARING, FATIGUE, ETC.) <input type="checkbox"/> LACK OF KNOWLEDGE OR SKILL <input type="checkbox"/> NO UNSAFE PERSONAL FACTOR <input checked="" type="checkbox"/> OTHER			
26. WHAT HAVE YOU PERSONALLY DONE TO PREVENT SIMILAR INCIDENTS?			
27. WITNESSES TO ACCIDENT			

SIGNATURE

EXHIBIT K

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# PLAN HOLD

## SUPERVISOR'S REPORT OF INJURY

1. EMPLOYER <b>PLAN HOLD CORPORATION</b>		3. NATURE OF BUSINESS <b>SHEET METAL FABRICATION</b>	
2. LOCATION <b>17421 Van Karman Ave - Irvine CA 92714</b>			
4. NAME OF INJURED EMPLOYEE <b>FRANK JAMAICA</b>		5. SEX: <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
7. DEPARTMENT IN WHICH REGULARLY EMPLOYED <b>ASSY</b>		6. OCCUPATION <b>ASSY</b>	
8. SUPERVISOR <b>Jim</b>		10. ON EMPLOYER'S PREMISES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
9. WHERE DID ACCIDENT OR EXPOSURE OCCUR? <b>ASS-1</b>		11. WHAT WAS EMPLOYEE DOING WHEN INJURED? <b>WORKING ON A MASTER FILE</b>	
12. HOW DID ACCIDENT OR EXPOSURE OCCUR? <b>when He was moving the master file</b>			
13. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE			
14. NATURE OF INJURY OR ILLNESS AND PART OF BODY AFFECTED <b>muscle strain</b>			
15. DATE OF INJURY OR ILLNESS MO <b>4</b> DAY <b>19</b> YEAR <b>96</b>		16. TIME OF DAY A.M. <b>1:00</b> P.M.	
17. HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> YES, DATE RETURNED <input checked="" type="checkbox"/> NO, STILL OFF WORK			
18. WAS FIRST AID ADEQUATE TREATMENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		19. DID EMPLOYEE GO TO THE DOCTOR? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20. IF YES, NAME OF DOCTOR OR CLINIC <b>Local Doctor</b>		21. DID AN UNSAFE CONDITION CONTRIBUTE TO THE ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
22. EXPLAIN			
23. DID THE EMPLOYEE COMMIT AN UNSAFE ACT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24. EXPLAIN			
25. PERSONAL FACTORS THAT COULD HAVE CONTRIBUTED TO THE ACCIDENT <input type="checkbox"/> IMPROPER ATTITUDE <input type="checkbox"/> BODILY DEFECTS (EYESIGHT - HEARING, FATIGUE, ETC.) <input type="checkbox"/> LACK OF KNOWLEDGE OR SKILL <input checked="" type="checkbox"/> UNSAFE PERSONAL FACTOR <input type="checkbox"/> OTHER			
26. WHAT HAVE YOU PERSONALLY DONE TO PREVENT SIMILAR INCIDENTS?			
27. WITNESSES TO ACCIDENT			

SIGNATURE

EXHIBIT L

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2362 Morse Avenue  
Irvine, CA 92714  
(714) 863-91033100 W. Warner Ave.  
Santa Ana, CA 92704  
(714) 546-423322741 Lamb Street  
Lake Forest, CA 92630  
(714) 71-30In  
Dr.

Physical Therapy

Out

Am 2 11

79353  
**WORK STATUS FORM**Employee: Jamaica FrankEmployer: Plan Hold

0.07/19/96

Out

RIGHT OR LEFT		DIAGNOSIS				
Abdomen	Ear	Heel	Shoulder	Abrasion	Dislocation	Overuse
Ankle	Elbow	Hip	Skin	Abscess	Epicondylitis	Syndrome
Back	Eye	Index Finger	Skull	Allergy	Foreign Body	Paronychia
Big Toe	Eyebrow	Jaw	Teeth	Amputation	Fracture	Puncture
Calf	Face	Knee	Tendon	Avulsion	Ganglion Cyst	Rust Ring
Cervical	Finger(s)	Lip	Thigh	Burn - Thermal	Hematoma	Sprain
Spine	Digits: 1 2 3 4 5	Lower Leg	Thumb	Burn - Chemical	Hernia	Strain
Chest	Foot	Lumbar	Toe(s)	Bursitis	Infection	Subungual
Chin	Forearm	Spine	Tongue	Carpal Tunnel	Inflammation	Hematoma
Coccyx	Forehead	Nail	Upper Arm	Cellulitis	Inhalation	Tendinitis
Conjunctiva	Groin	Neck	Wrist	Chemical	Irritation	Tenosynovitis
Cornea	Hand: <input type="checkbox"/> R <input type="checkbox"/> L	Nose		Conjunctivitis	Laceration	Trauma
Dorsal	Dominant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Rib		Contusion	Myositis	<input type="checkbox"/> Non-Occupational
Spine	Head	Scalp		Dermatitis	Neuritis	

Other/Comments:

epididymitis 2° to  
strain of the groin → SEE Anti-B 2  
- schedule surgical consult.

WORK STATUS		PHYSICAL THERAPY	
<input type="checkbox"/> Off Work	thru	Yes	No
<input checked="" type="checkbox"/> Return to Work with Limitations (see below)	4/26	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Return to Full Duty Unrestricted	thru	Frequency: <input type="checkbox"/> Daily	
<input type="checkbox"/> Discharged to Return to Work Unrestricted	DATE	<input type="checkbox"/> 3 Treatments	
		<input type="checkbox"/> 2 Treatments	
		<input type="checkbox"/> Evaluate and Treat (First P.T. Visit)	
		<input type="checkbox"/> Protocol	
		Precautions/Special Instructions:	
		Scheduled with Another Facility <input type="checkbox"/>	

**NOTICE OF LIMITATIONS** ☐ FIRST NOTICE ☐ REVISED NOTICE ☐ NO CHANGE FROM PREVIOUS VISIT

- ☒ Lifting or carrying: Not permitted to lift, carry, push or pull more than 5 pounds.
- ☒ Sedentary bench or desk work preferred.
- ☐ Repetitive, awkward positions: Must avoid repeated bending or motions of the \_\_\_\_\_
- ☒ Bending and stooping: Must avoid repetitive bending, stooping or squatting.
- ☒ Walking or standing: Should avoid prolonged or sustained walking or standing.
- ☒ Work at ground level: Not permitted to work on ladders, scaffoldings, poles, roof or above ground level.
- ☐ Hazardous machinery: Not permitted to operate hazardous machinery or tools.
- ☐ Motor vehicles: Should not operate personal or company vehicle.
- ☐ Ventilated area: Work area must be adequately ventilated.
- ☐ Solvents and other chemicals: Must avoid contact with solvents, oils, acids, detergents or other chemicals.
- ☐ Keep clean and dry: Wound site and all dressings, bandages, etc., must avoid exposure to liquids, dirt, grease, oils or other contaminating agents.
- ☐ Overhead lifting: Must avoid overhead work.
- ☐ Eye patch: Must wear eye patch as directed and avoid hazardous machinery and driving.
- ☐ Splint/Brace: Must wear as directed.
- ☐ Special and Miscellaneous: \_\_\_\_\_

CIGA 3547

Medical Provider

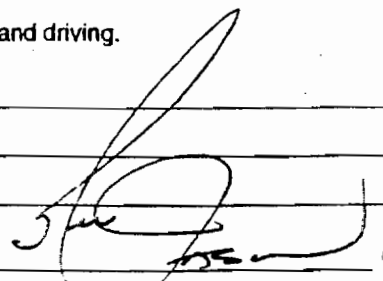
  
# 30

EXHIBIT M

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DOCTOR'S REPORT OF OCCUPATION INJURY OR ILLNESS  
STATE OF CALIFORNIA

In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics & Research, P.O. Box 420601, San Francisco CA 94142-0601, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS ZURICH AMERICAN INS CO PO BOX 2400 WOODLAND HILLS CA 91365			PLS DO NOT USE THIS CODE:
2. EMPLOYER NAME PLAN HOLD CORPORATION			Case No:
3. Address: No. and Street 17421 VON KARMON		City IRVINE	Zip CA 92714
4. Nature of Business SERVICE			Industry:
5. PATIENT NAME (First, mid, last) FRANK JAMAICA		6. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth 04/08/60
8. Address: No. and Street 2115 SPARK DR. SANTA ANA 92701		9. Telephone number (714)-979-5211	Hazard
10. Occupation (Specific job title) ASSEMBLY		11. Social Security # 561-99-1776	Disease
12. Injured at: No. and Street POE		City IRVINE	County ORANGE
13. Date/hour of injury or onset of illness MM/DD/YY 04/21/96 12:00am 12:00pm		14. Date last worked 04/23/96	Occupation
15. Date/hour of first exam/treatment MM/DD/YY 04/23/96 am 04:55pm		16. Have you or your office previously treated pt? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Rtn Date/Code

Patient please complete this portion, if able to do so. (Use reverse side if more space is required)

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical.)  
THE ACCIDENT HAPPENED WHEN HE WAS WORKING IN THE LINE AT WORK. HE WORKS ON A TABLE, THE TABLE STARTED TO ROLL, HE FELL INTO THE SPLITTS. GROIN INJURY.

(PATIENT'S HANDWRITTEN SIGNED DESCRIPTION ON FILE)

18. SUBJECTIVE COMPLAINTS SEE OTHER SIDE The patient states that one year ago, he was involved in an accident at his workplace in which he was holding	DIABETIC: NO ALLERGIC: NKDA TETANUS IMM: 5.5
--	--

19. OBJECTIVE FINDINGS A. Physical examination: BACK - The gentleman has a slightly antalgic gait in that he walks slowly. He is able to bend over and touch his toes. He has no low back tenderness or tenderness along the inguinal ligament. The only area of
---

20. DIAGNOSIS (ICD9CM code) 604.9 ORCHITIS	Chemical or toxic agents involved? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No N/A
---	---

21. Are findings & diagnosis consistent with patient's account of injury or onset of illness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "no", explain. N/A
--

22. Is there any other current condition that will impede or delay patient's recovery? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "yes", explain. N/A
--

23. TREATMENT RENDERED <input checked="" type="checkbox"/> Medical <input type="checkbox"/> First Aid NAPROXEN 500 MG #14	EVALUATION & MANAGEMENT
--	-------------------------

If further treatment required, specify treatment: RE-CHECK 04/26/96 12:00AM Estimated duration [7] days

24. If hospitalized as inpatient, give hospital name and location.	Date MM/DD/YY	Est. stay admitted
--	------------------	-----------------------

25. WORK STATUS Is patient able to perform usual work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
--

Modified Work: 04/27/96

Specify restrictions: NONE

Dr's signature DAVID DUNCKEL, M.D.	Date 04/25/96	CA lic. # A-041252
Address 11420 WARNER AVE. FOUNTAIN VALLEY CA 92708	Phone (714)-442-3444	IRS # 95-2653450

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS' COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

CIGA 3514

Patient: JAMAICA, FRANK Medical Record #: 460270 Date of Service: 4/23/96

Employer: PLAN HOLD CORPORATION (3119P) Date of Injury: 04/21/96

===== DOCTOR'S FIRST REPORT : 5021 (cont'd) =====

SUBJECTIVE: (continued from front of 5021)

up a heavy box and the tables that he was standing on flared out and he did the splits and injured his groin area. This was greatly manifested by testicular pain. He states that he was offered anti-inflammatories and rest and that they finally had him sign a piece of paper and he settled it. He did not continue receiving treatment and he stated that his testicle and groin area were sore at a low level off and on since that time. However, this last weekend, I believe he reported to me that it was Sunday even though he did not fill it in on the first report, he was helping bring down a heavy cabinet which weighed 200 lb and he felt a strong pull in his right groin area. Since then, he has had pain that he describes as in the testicle and also radiating up around the right lateral groin area into the low back and also some difficulty urinating at times. He stated he reported this immediately to his supervisor and asked several times to be sent to their clinic. He states that he was not given permission to go and thus, in frustration he came to see us. He presents at our walk-in clinic.

OBJECTIVE:

NOT TRUE  
tenderness is the right testicle which is riding somewhat higher than the left. He complains of a lot of tenderness on palpation. It does not feel overly swollen compared to the other side. There is no lymphadenopathy. Urinalysis was 1+ blood on the dipstick, however on microscopic examination, there are only 2-5 red blood cells seen. No white cells are seen.

ASSESSMENT:

XRAY/LAB:

Probable traumatic orchitis.

DIAGNOSIS: 604.9 ORCHITIS

PLAN / TREATMENT:

1. The history of the pre-existing low-level of testicular pain without the patient knowing what the diagnosis was could be a contributing factor in his recovery.
2. The patient was advised to take a few days off work where he is at bedrest.
3. Naprosyn 500 mg b.i.d., dispense 14.
4. Work status, unable to do regular work for four days.
5. We will re-evaluate him in three days. /lm

=====

Treating Physician: DAVID DUNCKEL, M.D. PHONE: (714) 442-3444  
11420 WARNER AVE. FOUNTAIN VALLEY

EXHIBIT N

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1 a second continuous trauma injury that ended in April  
2 of 1996. Does April of 1996, does that sound like  
3 what you are talking about now?

4 A What do you mean when you say "finished"?

5 Q Maybe your attorney would like to explain  
6 that to you what a continuous trauma injury is.

7 MR. THOMPSON: It's a stress and strain of job  
8 duties over a period of time.

9 THE WITNESS: I don't understand.

10 MR. THOMPSON: I don't know how to explain it  
11 more simply. It is an injury that occurred as a  
12 result of repetitive job activities.

13 THE WITNESS: The pain never went away. In '96  
14 is when I had my second injury.

15 BY MR. KATSELL:

16 Q Was that in April of 1996?

17 A I think, yes, it was in April.

18 Q Are you sure it was in 1996?

19 A Approximately. I believe that's when it  
20 was.

21 Q Now that would have been more than a year  
22 after your first injury. If your first injury was in  
23 January of 1995, and your second injury was in April  
24 of 1996, there would have been approximately 15 months  
25 between injury one and injury two. So I just want to

1 make sure that's what you are telling us.

2 A Yes, approximately.

3 Q What happened in approximately April  
4 1996, if you can tell us that?

5 A I was doing my regular work. I was  
6 working with the master files. I had already finished  
7 one unit. I was pushing it. That's when I felt this  
8 pain, this very strong pain in my testicle and a lot  
9 of discomfort on my shoulder.

10 Q That would be the left shoulder?

11 A Yes.

12 Q Was this an increase in pain in your left  
13 testicle or -- excuse me, in the right testicle, more  
14 pain than you had experienced in the period before  
15 that -- in the months before that?

16 A Yes, it was a stronger pain. Even my leg  
17 got swollen because of that.

18 Q Was that your right leg?

19 A Yes, the right leg.

20 Q Did you also on that day in April when  
21 you were pushing a unit of the master file and felt  
22 increased pain, did you also feel increased pain in  
23 your left shoulder as compared to what you had been  
24 feeling the preceding months?

25 A Yes, it increased.